"They brought my smile back": A phenomenological description of widows' experiences of psychosocial support

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ABSTRACT

The consequences of widowhood can be overwhelming. Widows sometimes experience difficulties to obtain psychosocial support to overcome the challenges they face. In this phenomenological study, purposively selected widows were asked about their experiences of widowhood in terms of different sources of support. The analysis illuminated the meaning widows attach to different sources of psychosocial support. Participants experienced both positive and negative encounters with their sources of support. During negative encounters, widows experienced feelings of disappointment; and when their psychosocial support needs were met, they experienced a sense of happiness and a positive level of satisfaction.

Keywords: grief**,** psychosocial support of widows, spousal loss, widowhood

All over the world, widows across all ages share common challenges (Dasgupta, 2017). Widowhood affects the individual's physical, psychological, social and spiritual functioning (Agrawal & Keshri, 2014; Ory & Huijts, 2015; Kim & Kim, 2016). Becoming a widow is associated with a 48% increase in mortality risk. There is a strong relation between social support and widows' health status and mortality (Sullivan & Fenelon, 2014). Jacobson, Lord, and Newman (2017) found that higher anxiety symptoms predicted lower emotional social support and lower emotional support predicted higher depressive symptoms in widowhood. These findings confirmed the importance of social support in moderating health risks during widowhood.

Signs of psychosocial distress such as emotional turmoil and social isolation indicate that widows need support (De Vries, Utz, Caserta, & Lund, 2014). Responding to widows' psychosocial support needs may assist them to adjust more effectively to the social and environmental challenges they face (Adebowale, 2015). A lack of appropriate and meaningful support to widows affects their ability to adjust to the demands of widowhood (Perkins, Lee, James, Oh, Krishna, Heo, & Subramanian, 2016). Widows' struggle to adapt to the changed circumstances could make them susceptible to physical and mental health conditions, and also affect forthcoming generations in different areas of life (Dasgupta, 2017; Widows' Rights International, 2011).

Although multiple types of support are offered to the widow during the first months of the loss, emotional support and the amount of support provided by family members diminished across time, as people assume that the widow has adjusted well (Powers, Bisconti, & Bergeman, 2014). But even widows who appeared to have adjusted in all situations, still need social support (Behera & Bhardwaj, 2015). Becoming lonelier as time passes, increases widows' risk to develop depression and make them more vulnerable to the effects of depression (Kim & Kim 2016; DiGiacomo, Davidson, Byles, & Nolan, 2013).

Some widows find it difficult to maintain social relationships (Bharathi, Sridevi & Kumar, 2015), while others manage to maintain stable levels of structural and functional support (Powers et. al., 2014). Many factors influence the types of social support widows and widowers can access and make use of. For example, middle-aged widowers are less likely to receive emotional support as influenced by gender norms (Rafieei, 2013). Also, successful adjustment during widowhood is not only reliant on social support. Both widows' internal and external resources play a role in coping - social factors such as support structures,

engagement, and social responsibilities interact with internal characteristics such as confidence, courage, independence, and problem-solving abilities (Hendrickson, Kim, Tol, Shrestha, Kafle, Luitel, Thapa, & Surkan, 2017).

The first author of this article is a lecturer in Mental Health Nursing, and a widow herself. She communicated with widows at various settings, and many of these widows verbalised that life was not easy following the death of their spouses as they experienced difficulties to adapt to their changed circumstances. Despite the widows need for psychosocial support, they avoided asking for help as they did not want to become a burden to others. Similarly, a Nigerian study (Adebowale, 2015) found that widows tend to suffer in silence due to a lack of psychosocial support, a situation that affects their children. Not only widows, but also families and communities are affected when widows' emotional pain goes unnoticed and/or they struggle to mobilise available support systems.

The growing ageing female population is vulnerable to the consequences of loneliness (DiGiacomo, Lewis, Nolan, Phillips, & Davidson, 2013). Research to understand and strengthen social support networks (Dasgupta, 2017)**;** social interactions and social dependability may contribute to ensure resilient outcomes for widows **(**Powers et al., 2014). Research also needs to establish the role that families play in bereavement outcomes, including the types of interactions between family members and how these interactions influence, in a positive or negative way, the intensity of grief (Stroebe & Schut, 2015). Lastly, we need to listen to the experiences of widows to understand the multiple and complex narratives of their lives, instead of assuming that widowhood is a time of loneliness, health problems and misery (Chambers, 2005).

In South Africa, a multi-cultural society, studies on widowhood mostly explored how different socio-cultural norms and values affect mourning (Somhlaba & Wait, 2009; Manala, 2015; Makgahlela, Sodi, Nkoana, & Mokwena, 2019), while no studies could be found on psychosocial support of widows in South Africa. The aim of the study was to explore and describe the experiences of widows in relation to the support they received from different sources, with an aim to propose recommendations to promote psychosocial support for widows.

Method

The present analysis is part of a larger study to develop guidelines to support widows in an urban area of South Africa. Approval to conduct this study was granted by Research Ethics

Committee of the Faculty of Health Sciences, University of Pretoria (107/2015). A descriptive phenomenological inquiry as outlined by Giorgi (2009) and Dahlberg, Dahlberg, and Nyström (2008) were used as to explore widows' lived experiences. Widows attending widows' events in the City of Tshwane, South Africa were invited to participate in the study. This target population was accessible to the first author, who attended some of the events herself. Purposive sampling was used to select potential participants. Widows needed to be able to communicate in English and be older than 18 years to give informed consent. The researchers believed that widows who lost a husband at least a year ago but less than five years before, and who stayed with the spouse during the time of death, would best be able to recall their experiences of support.

Participants were given essential information about the interview procedure, the expected duration of the interview, and the possibility of experiencing emotional discomfort when talking about the loss of a partner. Participation was voluntary, and each participant signed an informed consent form. Although the interviewer arranged with a counsellor to be available, no participant required emotional support during or after the interview. The audio-recorded and transcribed interviews were numbered; and care were taken not to mention participants' real names in the recording of findings to maintain confidentiality and anonymity.

Prior to conducting the unstructured individual interviews, the first author discussed her pre-understanding and assumptions regarding the phenomenon of widowhood with the study supervisors. All these were recorded as reflective notes and bracketed to ensure the interviewer maintained an open attitude to the experiences of the participants (Dahlberg et al., 2008).

Participants were interviewed in a private room and the interviews lasted for a maximum of 60 minutes. The interviewer used facilitative skills to ensure participants communicated freely. Responses were paraphrased to enhance understanding and unclear responses were clarified using open-ended questions. The interviewer kept field notes of participants' non-verbal communication as well as reflective notes of her own feelings and ideas to enhance bracketing (Polit & Beck, 2017).

Participants shared comparable cultural viewpoints, standards and practices as they were from Sepedi, Sotho and Tswana ethnic groups that form a large segment of the residents in the City of Tshwane, South Africa. Data saturation was reached by the fifth participant, but the researcher interviewed seven more widows to ensure that there was no new information

surfacing in the data collected. The last seven interviews did not provide new data, but repetition of information expressed differently, but with similar meaning (Englander, 2012; Giorgi, 2009). The participants' ages ranged between 25-65 years.

Four steps of Giorgi's (2009) phenomenological method were used to guide the data analysis. Firstly, the researcher bracketed her own pre-knowledge of widowhood to be open and receptive towards the participants' narratives of their experiences with different sources of social support. Secondly, she read the transcribed interviews to comprehend the whole meaning of the widows' experiences as lived by them. Thirdly, the researcher reread the transcripts and selected sections with similar meaning, described as "meaning units" in phenomenological research. During the last step, the researcher began to understand the data more deeply and meaning units were clustered together and transformed into statements consistent with the phenomenon under study. Meaning units formed a pattern and were described in relation to other meanings. The new and deeper understanding is reflected in the description of participants' experiences.

Results

The findings indicated that widows interact with their social environments to seek meaningful support to survive the difficulties of widowhood. Participants received support from different sources, namely, family and friends, colleagues and employers, peer group members, spiritual counsellors and health care providers. Widows communicated both positive and negative encounters related to the support received from different sources. Positive support was valued as it filled them with hope and contributed to their emotional healing. On the contrary when the support needs of widows were not met, they felt desperate and disappointed.

Verbatim quotations, reflecting the participants' experiences, are indicated with the participant's number in brackets, for example, (P1).

Family and friends as a source of support

The importance and value of support from family and friends were emphasised by all participants. The participants appreciated the support that took their minds off their sorrow and pain and enabled them to laugh again, as illustrated in the following quotation:

> My friends and family support me. They are good to me...they are there when I need them. Things are tough for me at times and they are always there to listen to me. They keep me busy so

> that...I keep my mind occupied and not think about my problems. They always invite me to spend time with them...talking and laughing about things. That really helps… (P7)

Some of the participants regarded themselves fortunate to have access to support from their in-laws that gave them hope and peace of mind as illustrated in two of the participants' quotations:

> My in-laws still care for me. They call me almost every day just to check on me and the kids...My mother in law stayed with me for at least two weeks after my husband's death. ....But she has her own life...home to take care of, and I understand, you know. **(**P1)

> …especially with the support that I got from my in-laws. They supported me very much and without their support I don't think I could have made it, because with their support I could stand and see that there is still life for me…and my children…I just felt blessed being in their life or having them in my life...I felt so blessed and it was encouraging me…that at least, after all my in-laws are not fighting me...meaning that...wherever my husband is...he is happy because we are united in the family. (P5)

To some of the participants, the lack of support from family and friends including the in-laws was a serious concern. The cultural repercussions of not having contact with the in-laws who are supposed to play a major role during mourning, for example, children's marriages, are illustrated in the next quotation:

> I invited them [the in-laws] to my children's graduation party but they never came or send a word or anything...this worries me a lot because my children will still need to get married in future... "ke mang a tlo ba...a tlo ba tlhokomelang'' [who will take care of them?]..I mean the aunts are the ones who should be leading the way...you know our tradition...there are always expectations...certain things that can only be done by the in-laws. This hurts me a lot...it worries me...how am I going to handle it when it comes? It bothers me a lot. (P12)

The support from significant others was regarded as an integral factor that enabled widows to cope and assisted them with the process of healing.

Work colleagues as a source of support

The value of the support received from employers and colleagues was expressed by some participants. A colleague provided a listening ear and an employer some encouragement:

…my colleague is very supportive....she also lost her husband...I often call her when feeling that all is becoming too much for me... (P2)

My employer is a very understanding person. She is a Christian, she always tells me that God is there for me, but some things are just too much for me to handle. (P3)

The impact of the support provided by colleagues, both practically and emotionally, was illustrated by one participant as follows:

…my colleagues helped me a lot...they were there from day one when I was still confused...not knowing where to begin...they carried me through...some of them used their own transport to help me organise the funeral...they counselled me.....they are there for me when I want to talk. (P5)

The support widows received from their work environment was much appreciated as it seems to have enabled widows to cope with different challenges.

Other widows as a source of support

Support from other widows appeared to be an important factor in increasing the widow's sense of belonging and security. One widow put it as follows:

It taught me that sometimes people that you least expect are the ones who help you...my in-laws were not there for me.....but having other people...widows around me....to help me was helpful...you know it is true that...what they say...God will never forsake you...a good Samaritan will always be there...those people helped me a lot. (P12)

The value of mutual understanding amongst fellow widows is illuminated as follows:

…there was one lady whom the husband died before...she couldn't utter a word...she didn't even say anything but she was seated there....this person knows what I am feeling...how I am feeling....I experienced that very much helpful....to be supported by the person who knows what you are going through...that made me strong....knowing that at least....other widows are there to support me...it made it easier...they gave me strength and hope. Seeing them being so willing to support…it was touching...maybe is because they have been there before... (P5)

Being in contact with another widow while feeling vulnerable triggered a feeling of sympathy, a sign that the widow can reach out to others instead of just focusing on her own pain, as illustrated in this quotation:

> ...when I see a widow either in a mall or shop...especially these young ones...I feel like just going to them and hugging them...to me is a sign of healing because if I can feel sorry for somebody, it means I am healing because in the beginning I felt sorry for me and me only...so now I can look at another widow and just think…I have been there…I know what you are going through and I am sorry... (P10)

The significance of mutual understanding amongst widows who went through similar experiences seems to enhance a sense of comfort, hope and security. Widows who did not receive peer support; felt that such an opportunity would promote their sense of acceptance and belonging as was illustrated in the next quotation:

> ...Sister, I think I will be more comfortable talking to someone who went through the same experience...who was a widow herself...someone who understand me better...to give me a hope...to tell me that things will be ok...and advise me how to handle my frustration and stress... (P12)

Spirituality as a source of support

The value of spiritual support was emphasised by some of the participants. Their spiritual well-being was enhanced through church attendance, counselling from priests and prayers from church members. Widows prayed together and met with other widows at church to support each other as illustrated in the following quotation:

> My priest is always counselling me whenever I am at church. That really makes me feel better…every year during women's month in August our church organises something for widows. We me**e**t as widows...we talk about our problems...we give each other support...that helps a lot. (P6)

The need for spiritual support was illustrated when one participant commented that spiritual support and having faith in God surpasses even financial support:

> …you can have money or maybe you can't have money but the most important thing is that as a widow you must trust in God....as the Bible says....God is the husband of widows....so people must be encouraged to trust in God… (P5)

Spiritual support from church leaders or fellow church members and having faith in God provided widows with emotional comfort and enhanced their process of healing.

Health care providers as a source of support

The importance and the need for support from health care providers were emphasised by all participants. Health care providers such as nurses, social workers and psychologists were seen as an important part of the support system, especially during the first weeks and months following the start of widowhood. However, the widows in this study experienced encounters with health providers as both positive and negative. During negative encounters with health care providers, some of the participants experienced feelings of disappointment at how they were treated by nurses at the local clinics; nurses who seemed not to be concerned or displayed a lack of commitment towards the widows' needs:

> I am not happy about the care that I received from the clinic. I waited for three hours, only to be told that I must try to take it easy and the sister only gave me Panado...she could have checked me thoroughly... I wanted her to tell me that I will be ok, that the pain will be ok. At least take her time to check what was wrong with me. I felt that she was in a hurry. I was just another client who only needed to waste her time. (P1)

The feelings of disappointment with being treated with a lack of interest and care were expressed as follows:

> …the nurses there are impatient...they do not have time for us...time to listen. All they care about is pushing the queue....I remember her telling me that she must see another patient before her going to tea time.... it was as if I was wasting her time. I could see that she was not interested in things that I was saying. She just wrote on the file without checking me. It simply means that she does not care and I was only wasting her time. I was not impressed at all…I was there to get help…not to be treated like I am...I am nothing… (P3)

Participants perceived the approach of health care providers as negative as it was not "caring" and "nurturing". They felt a sense of dissatisfaction and experienced the care from the health

care providers as generalized and impersonal in that their needs as widows were not met. One participant described the care as inhumane, as if rendered by a robot:

> The support is there but the support is like general...is not directed at widows *per se*...they check you...give you whatever it is that they need to give you, is like they are robots...they just check you and off you go…their support is not for widows...the support is for everybody else with physical needs....because our primary health services are over loaded and under staffed...they work like robots as I said...fast and in a hurry to push...push the queue...I am not happy about the support from the clinic...I feel that we are a statistic...you are just one in a million... they do not look at your situation...as a widow...I am not angry with them but I am not happy… (P10)

However, when participants' individual expectations were met such a situation had a positive effect on their level of satisfaction. They experienced the personalized care as positive and valued the non-judgmental and the caring approach displayed by some of the health care providers (nurses and psychologists) as they made them feel welcome and respected:

> I am fine with the support....talking to the nurses and the psychologist makes me feel better…I feel comfortable talking to them....they are not judging me. I am happy with the care that I received from the clinic, they respected me and never made me feel uncomfortable and I was free to talk about my problems… (P4)

The need for adequate attention from the health care providers was expressed by all participants. Some were grateful to those health care providers who had shown a sense of understanding. As explained by the next participant, the support encouraged her to smile again:

> They all listened to me...the sister and the psychologist...they were understanding.... and what they said to me made sense...it was as if they were reading my mind....what I was thinking…They gave me the attention I needed and I have learnt a lot from them. They brought my smile back and motivated me…they were all giving themselves time for me…their advice helped me...they motivated me a lot. I am grateful for their support… (P7)

Some of the participants were satisfied with the way that health care providers at the local clinics managed them as they received advice, health care education and reassurance. The following quotations indicate that participants were content and happy when they received support:

> They advised me to write all my fears and feelings down ....then we spoke about them each time I went to the clinic for my check-up. …Talking to the nurses at the clinic helped me…The sister said it will be better with time... (P4)

> I was young so they advised me about contraceptives and how to protect myself from infections should I decide to get involved with someone else…the clinic is my place of support and I am happy with their support as I indicated that they were there when I needed them the most...when I needed information...they gave it...they supported me even today. They tried their best to make me feel better... (P8)

In addition to the service rendered by nurses at the clinic, some of the participants found it helpful when they were appropriately referred to other health care team members such as a psychologist or social worker:

> The nurse also referred me to the clinic psychologist...she has also been helpful.... (P4)

> …the social worker was there for me…I am glad that I was taken to her… (P7)

Some participants who were not referred made recommendations in this regard as illustrated in the following quotations:

> …the most important support that widows need from the primary health care services is the psychological support...you need some psychotherapy...people who can just sit with you or have support groups…maybe even refer us to relevant services…and say: 'I can see you have this condition but I think you need somebody...a professional that can talk to you about this'; so they could have maybe a resident psychologist...maybe it could help widows a lot…the social workers or someone should assist us with this… (P10)

> …they can refer that person to the spiritual...father or the pastor...that is the support that...the widows need. (P5)

Discussion

Participants indicated that they needed and valued support from different sources to help them to move on with their lives. Widows need psychosocial support from family, friends, work colleagues, spiritual groups and health care providers. The findings of this study are in agreement with earlier studies (Nnodim, Ike, & Ekumankama, 2013; Rosenblatt & Nkosi,

2007), that a widow who is not given the much needed attention and support could become a burden to herself, her family and the entire community.

Loneliness makes widows question their very existence. The death of a spouse not only means a sudden lack of companionship, but widows often question whether life is worth living alone (Dasgupta, 2017). Powers et al. (2014) found that life satisfaction in widows gradually declined over the first year, but gradually increased across the second year of bereavement. It is during this time of loneliness and decreased life satisfaction that psychosocial support plays a crucial role in how widows experience and adjust to spousal death (Hendrickson et al., 2017). Recently widowed women who participate in social activities suffer less from depression (Kim & Kim, 2016).

As illustrated in this study, the emotional experiences of widows are not only influenced by contact with friends and family, but also the level of satisfaction with these relationships. De Vries and colleagues (2014) found that higher satisfaction with relationships is associated with lower scores of negative emotional responses to the loss. The ease of contact with friends and family was positively associated with widows' feelings of mastery, coping, self-efficacy, and self-esteem. However, high frequency of social contact was related to higher grief and depression. The authors suggested that this finding may reflect the emotional turmoil widows experience as they try finding a new equilibrium and ways of relating. Monserud and Markides (2017) also found that greater social support was related to more depressive symptoms in widows of Mexican descent. These authors ascribed the finding to widows who feel that they are not able to reciprocate the social support resulting in a fear of becoming a burden to family and friends. Anusic and Lucas (2014) mentioned that early support did not seem to contribute to recovery from the loss of a spouse. Their findings that later support was positively associated with adaptation to widowhood were also not statistically significant in all datasets.

The degree of support needed is related to the experience of the loss. Respondents who expected the loss, but experienced it as everyday-disruption (e.g., the death of an ageing and ill partner), were satisfied with the level of support from family and friends, but most of them also made use of available bereavement programs such as community support groups or faith-based support. Respondents who experienced the loss as unexpected and disruptive (such as a younger spouse), considered the support they received to be inadequate and required specific mental health interventions (Aoun, Breen, Howting, Rumbold, McNamara, & Hegney, 2015). Similarly, the National Institute for Clinical Excellence (2004) in the

United Kingdom has proposed a 3 tiered approach to bereavement care and support. Family and friends can offer support to those with normal grief; trained volunteers and self-help groups can give nonprofessional support for bereaved people who need more reflection on their loss, while people with more complex needs at risk of complicated grief would need professional and specialist interventions.

The abovementioned approach is confirmed in a study by Bellamy, Gott, Waterworth, McLean and Kerse (2014), where older bereaved spouses questioned the role of, need for and value of formal bereavement support services. The participants who expected the loss felt able to cope with the emotional and practical challenges associated with the loss. This highlights the value of strengthening existing bereavement support structures such as family, friends and community and religious organisations. This is of particular importance in countries where the provision of specialized bereavement support is restricted due to lack of resources (Bellamy et al., 2014).

Parallel to the results of this study, widows who saw other widows live meaningful lives, felt more hopeful about their own lives (Asai, Fujimori, Akizuki, Inagaki, Matsui, & Uchitomi, 2010) and enabled them to empathize with and help others because of their experiences (Wilson & Supiano, 2011). Their participation in social activities with other widows play an important role in problem-solving and provide opportunities to widows to receive social support and ease access to economic or social resources in their communities (Hendrickson et al**.,** 2017). Support groups and friendships aid widows in the grieving process. The support group becomes a source of mutual assistance and members apply their experiences from the support group to establish life after the loss (Hata & Kawahara, 2017). With regards to participants' experiences of support at the workplace, the authors' literature search did not yield any studies in this regard, except research by Jamadar, Melkeri, and Holkar (2015) who found that there are significant differences between working and nonworking widows' quality of life. Working widows have a better quality of life than non-working widows. Participants in this study valued the workplace support similar to that rendered by a caring friend of family member.

As in the study findings religious involvement may provide some widows with effective psychosocial support. Attendance of religious services was found to moderate the effect of widowhood with regards to depressive symptomatology (Monserud & Markides, 2017). Similarly**,** widows in Ghana described their spiritual and religious beliefs as sources of resilience when facing the challenges of bereavement. They combined both intrinsic and

extrinsic religious activities in their quest for meaning, purpose and survival (Korang-Okrah, 2015). As also mentioned by one participant in this study, Kaneez (2015) remarked that, while enduring the loss, the widow's ultimate focus remains on the relationship with God. Religious coping is recognized as a valuable resource during bereavement. Religious coping enhances a person's sense of mastery and self-esteem and search for and finding meaning (Kaneez, 2015).

In this study, widows experienced encounters with health care providers as both positive and negative. Health care providers may lack the relevant skills to identify widows in distress and render relevant support to these widows. Widows expressed dissatisfaction when support does not meet their unique needs**.** Perceived sense of dissatisfaction and disappointment were evident feelings which generally reflected participants' perceptions of inadequate care, nurturing and support provided by health care providers. It is important that health care providers appreciate individual differences and render bereavement support based on the widow's frame of reference (DiGiacomo et al., 2013; Lund, Caserta, Utz, & De Vries, 2010).

In this study, some of the widows appreciated the caring and nurturing approach portrayed by some of the health care providers. Cacciatore and Flint (2012) recommend compassionate bereavement care, based on mindfulness practice to create a therapeutic environment in which widows can grow within and beyond their losses. Such an approach requires the provider to engage with an open and non-judgmental attitude to enhance individual and cultural sensitivity. Providers are taught to integrate the aspects of the acronym ATTEND (Attunement, Trust, Therapeutic touch, Egalitarianism Nuance, and Death education), into the therapeutic relationship with the widow. The relationship is fostered through mindfulness, responsiveness, empathy, and self-awareness.

Widows in the current study expressed the need to be referred to appropriate health care providers such as psychologists, social workers or spiritual counsellors and seemed to be happy when the providers could assist them with their relevant needs. Community nurses who provide bereavement support within a person-centred framework, will be able to identify widows with complicated grief (Redshaw, Harrison, Johnson, & Chang, 2013). Structured screening and assessment should be done to ensure widows who need psychosocial interventions, are appropriately referred. Authors such as Hudson, Hall, Boughey, and Roulston (2018) and Boelen and Smid (2017) outlined referral pathways and criteria for referral, for example, grief symptoms that persist for more than six to 12 months, impaired

functioning, symptoms of depression or post-traumatic stress disorder associated with major role impairment, or suicidal ideation. Specialist interventions may include bereavement counselling and psychotherapy, sensitive to the patient's culture. In a South African context, traditional healers play a valuable role and they should not be left behind as they are often one of the primary sources of support to widows (Reid, 2016).

While this study focused on psychosocial support, the research on resilience shows that successful adaptation in widowhood relies just as much on widows' abilities to manage their social relationships and lives in creative, practical and flexible ways (Collins, 2011). Indeed, most women manage to overcome the disappointments of widowhood with creativity, resilience and growth (van den Hoonaard, 2003). High scores in psychological resilience and extraversion, conscientiousness, agreeableness and openness were associated with psychological adaptation to spousal bereavement (Spahni, Morselli, Perrig-Chiello, & Bennett, 2015).

Limitations of the study had been identified. The sample size was limited to only 12 widows residing in the City of Tshwane which is one urban area in South Africa. The participants were recruited at widows' events, and did not included widows who were harder to reach. Therefore; the findings are limited to the setting involved. The findings of this study are comparable to the findings from previous research on widowhood experiences, which led the authors to believe that the findings are likely to be applicable to widows from different settings. The findings of this study may be used to guide clinical practice and plan ongoing research related to the phenomenon of widowhood. It is recommended that future research should focus on the views of family members and health care providers on how widows should be supported on a psychosocial level and their challenges in this regard.

Conclusion

This article focused on the widows' needs for different sources of psychosocial support. The findings revealed that widows' experiences of support are individualized, as widows verbalized both positive and negative encounters with their sources of support. During negative encounters, widows experienced feelings of disappointment with the way they were treated. When participants' needs were met they experienced a sense of happiness and a positive level of satisfaction. Widows communicated their need for a caring and nurturing approach from health care providers and a need for appropriate referral to relevant systems of

support. The support that is perceived by widows to be adequate and appropriate may enable widows to cope with and adjust to changes related to widowhood.

The recommendations of the authors coincide with a bereavement care pathway proposed by Hudson et al. (2018). Community awareness of the importance of psychosocial support needed by widows should be promoted. Information regarding grief and bereavement should be available for health care providers and employers. The focus should be on identification of widows' own resources and capacity (internal and external strengths and resources) that will enhance their resilience. Health care providers should refer widows to specialized mental health care services when indicated, but should not underestimate the value of peer support and religious and spiritual beliefs and practices.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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